



**ProviderConnect  
Account Request Form  
Access to Multiple Provider Numbers**

Required fields are marked with an asterisk.\*  
Fax completed form to **866-698-6032**.

\*Name of staff member

\*Address

\*City \_\_\_\_\_ \*State \_\_\_\_\_ \*Zip Code \_\_\_\_\_  
( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
\*Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

\*Please check which Online Provider Services options you would like to have access to:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Electronic Batch Claims Submission (837 HIPAA format) | <b>Direct Online Functions:</b><br><input type="checkbox"/> Direct Claims Submission<br><input type="checkbox"/> Online Claims Adjustment | <b>Automatically included:</b><br><input checked="" type="checkbox"/> Eligibility Inquiry <input checked="" type="checkbox"/> Claim Status Inquiry<br><input checked="" type="checkbox"/> Authorization Inquiry & Submission<br><input checked="" type="checkbox"/> Provider Summary Vouchers/EOBs |
| <input type="checkbox"/> Online Claims Adjustment                              |   |  |

\_\_\_\_\_ @ \_\_\_\_\_  
\* Staff member's contact e-mail address – Please print

\_\_\_\_\_ @ \_\_\_\_\_  
E-mail address where you would like to receive your batch submission file feedback. - Please print.

- This is for a new login ID  
 We are adding a provider number to an existing Additional Login. Existing Login ID: \_\_\_\_\_

\*Please list the names and provider number of all the providers you will need access to with this account (Online Provider Services Account Request Forms must have been previously submitted, or with this form):  
You **must** also indicate what specific tax IDs that this user should be allowed access to under that provider number. All fields are required.

Provider Name	Provider ID (VO/State/ contract assigned unique ID – not NPI)	Tax ID(s)	NPI
John Doe	123456	123456789	9999999995
John Doe	UAW123456	123456789	9999999995

You may use additional sheets of paper if needed.

*Depending on the state in which you are practicing, you may need multiple accounts created to ensure the claims are processed accurately (i.e. Medicaid vs. Commercial). Therefore, to help us in setting up your account(s) correctly, if you are located in...*

- Colorado, will you be submitting CO Medicaid clients?  Yes  No, Commercial Only  Both
- Illinois, will you be submitting Illinois Mental Health Collaborative or ICG clients?  Yes  No, Commercial Only  Both  
If yes, will you be submitting Batch Registration Files?  Yes  No
- Kansas, will you be submitting either KS Medicaid Claims or AAPS Block Grant clients?  Yes  No, Commercial Only  Both
- Maryland, will you be submitting MD MHA clients?  Yes  No, Commercial Only  Both
- Massachusetts, will you be submitting MBHP clients?  Yes  No, Commercial Only  Both
- Pennsylvania, will you be submitting SWPA Medicaid clients?  Yes  No, Commercial Only  Both
- Pennsylvania, will you be submitting for the Non-HealthChoices Mental Health Program?  Yes  No Counties: \_\_\_\_\_
- Texas, will you be submitting TX NorthSTAR clients?  Yes  No, Commercial Only  Both



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Agreement Terms:

- A. The undersigned submitter authorizes ValueOptions to receive and process claims or batch registration submissions via the ValueOptions Electronic Transport System (ETS) or ValueOptions Online Provider Services Program on his/her/its behalf in accordance with the applicable regulations.
- B. All submitted information must be true, accurate and complete. I/We understand that payment of any claim submitted in falsification or concealment of a material fact may be prosecuted under any applicable state and/or federal laws.
- C. The Submitter agrees to comply with any laws, rules and regulations governing the ValueOptions Online Provider Services/EDI program.
- D. The Provider agrees to accept, as payment in full, the amounts paid in accordance with the fee schedules provided for under previously established agreements with ValueOptions.
- E. This is to certify that an exact copy of any claim files submitted via the ValueOptions ETS system or Online Provider Services program will be stored in an electronic medium and held by the originator for a period of 90 days or until the submission has been finalized as to reimbursement or denial of payment, whichever comes first.

Signatures:

\_\_\_\_\_  
Legal name of Organization

\_\_\_\_\_  
Title of individual signing for organization

\_\_\_\_\_  
\*Name of Individual Signing for Organization

\_\_\_\_\_  
\*Authorizing Signature

\_\_\_\_\_  
\*Date